SOUTHWESTERN MEDICAL CENTER

Ambulatory Services

Authorization to Disclose Protected Health Information

Pt. Name: .....
Address: .....
..... City State Zip
MRN: .....
DOB: .....
SSN: ..... SEX: .....
DOS: .....

Instructions: Complete and read sections 1, 2 & 3 to have information disclosed from Southwestern Medical Center or UT Southwestern Health Systems to another provider or requestor. Southwestern Medical Center or UT Southwestern Health Systems will not condition treatment, payment, enrollment or eligibility for benefits based on the completion of this form.

SECTION 1

Request Date:_____

Patient Name: Last:_____ First:_____ Middle:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Medical Record Number:_____ Social Security Number:_____

Telephone Number:_____ Date of Birth:_____

SECTION 2

A. I hereby authorize **Southwestern Medical Center or UT Southwestern Health Systems** to disclose my protected health information. I understand I may be charged a retrieval/processing fee for copies of my protected health information.

B. I would like to: ○ Receive copies of my medical record ○ Review my medical record*

**Note: Patients who wish to review their medical records should contact the Release of Information Supervisor at 214.648.2498, Option 2. All reviews are conducted in the Medical Records Department from 8:30am-4:30pm, Monday-Friday.*

C. Information to be released:

(Fill in all that apply)

○ Complete Medical Record (includes information regarding insurance, demographics, referral documents, and records received from other facilities)
○ Billing records
○ Radiology film/images (separate authorization required)
○ Other:_____ (specifically identify)
○ Other:_____ (specifically identify)
○ Other:_____ (specifically identify)

D. Time period or date of information to be released: From:_____ To:_____

E. The requested information above will be picked up by:

○ Patient or ○ Designee:_____
○ Mailed to the following address: Company/Name:_____
Attn:_____
Address:_____
City:_____ State:_____ Zip Code:_____

F. I understand that the purpose(s) of the requested use and disclosure is (are):

○ At the request of the patient ○ Other:_____

ROI:LEGAL

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SECTION 3

- I understand that, the records used and disclosed pursuant to this authorization may include information relating to: Genetic counseling, Human Immunodeficiency Virus (HIV) or Acquired Immunodeficiency Syndrome ("AIDS") treatment; history of drug or alcohol abuse, mental, behavioral health or psychiatric care.
- I understand that, I may revoke this authorization in writing at any time, except to the extent that Southwestern Medical Center has relied on this authorization. The written revocation should be addressed to the Release of Information Department. Unless otherwise revoked, I understand that the date or event upon which this authorization expires is **90 days** from the date of signature. A photostatic copy of this authorization is considered as valid as the original.
- I understand that, to the extent any recipient of this information, as identified above, is not a "covered entity" under the Federal or Texas privacy laws, the information may no longer be protected by federal and Texas privacy law once it is disclosed to the recipient, and, therefore, may be subject to re-disclosure by the recipient.
- I understand that, according to Chapter 159 of the Texas Occupational Code Section 159.005 (e), a re-disclosure could be made from records received from another health care provider involved in my care or treatment.
- Please direct all Release of Information inquiries to:

  Southwestern Medical Center
  Attn: Release of Information-Mail Code 8864
  5323 Harry Hines Blvd
  Dallas, TX 75390-8864
  214.648.2498, Option 1

Patient's Printed Name	Patient's Signature	Date
*Legal Representative's Printed Name	Legal Representative's Signature	Date

If representative, specify relationship to the patient

*Note[1] *Signing as the legal representative, I represent to Southwestern Medical Centerthat I am the legal representative of the patient. Should my legal authority terminate, I agree to provide written notification to Southwestern Medical Center.*

*Note[2] *Proof of legal authority may be required. For more information on qualifications to serve as a patient's legal representative, see Southwestern Medical Center's Guidelines for Legal Representatives.*

*Note[3] *If records are requested by an attorney, the attorney must provide the patient's authorization or proof of legal representation.*

Release of Information Use Only

Date received: _____ Date processed: _____

Processed by: _____ Date records mailed/picked up: _____

Date authorization revoked, if applicable: _____

Comments:

Form # MSP/ADPHI-001 / 09.03

ROI LEGAL